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AUTHOR Cross, Terry L.
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ABSTRACT

the report summarizes findings from a 1985 study that investigated service delivery problems and successes with emotionally handicapped Indian children in the Northwest. The study attempted to (1) estimate the approximate number of Indian children in Oregon, Washington, and Idaho who are seriously emotionally handicapped, developmentally disabled, or both; (2) identify current services to these children; (3) identify service delivery barriers to this population; and (4) identify exemplary programs and innovations for successfully addressing these problems. Existing relevant literature was reviewed and key informants were identified and contacted by telephone. The study found that some 11-to-20% of all Indian children appear to have some degree of emotional impairment but that only those whose conditions absolutely demand intervention receive treatment, largely because no single system has assumed primary responsibility for this population. Barriers related to the system (diffuse responsibility, lack of funding, isolation), to the community (needs for increased awareness, improved attitudes, and training), and to practice (need for culturally based diagnosis, lack of knowledge of etiology) were identified. Exemplary programs using a variety of approaches are cited, including group homes, prevention programs, and alcoholic treatment programs. The report concludes with recommendations and a selected bibliography. (VW)

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GATHERING AND SHARING: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children

Prepared Jointly By:

Research and Training Center to Improve Services for
Seriously Emotionally Handicapped Children and their Families,
Regional Research Institute for Human Services,
Portland State University

and Northwest Indian Child Welfare Institute,
a Project of Parry Center for Children

Principal Investigator: Terry L. Cross, ACSW
Research Assistant: Lisa Rylander

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Introduction

This is a summary of findings from an exploratory study investigating service delivery problems and successes with emotionally handicapped Indian children in the Northwest. The study was a joint venture between the Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families, a project of the Regional Research Institute for Human Services, Portland State University, and the Northwest Indian Child Welfare Institute. The research was carried out between July and November of 1985.

The purpose of the study was to increase the level of understanding of issues involved in providing services to emotionally handicapped Indian children. Since the mid-1970's Indian tribes and organizations have taken increasing responsibility for services to children through Indian child welfare programs, contracted mental health services, special education, and pre-school programs. The assumption of these responsibilities has brought a heightened awareness of children who suffer emotional problems. Identification of these children, culturally appropriate assessment and treatment, support services for families, and jurisdiction for service provision all present complex challenges.

The study's objectives were to:

1) Estimate the approximate number of Indian children in Oregon, Washington, and Idaho who are seriously emotionally handicapped, developmentally disabled, or both.

2) Identify current services to these children.

3) Identify service delivery barriers to this population.

4) Identify exemplary programs and innovations for successfully addressing with these problems.

The main components of the study were: 1) a review of the existing relevant literature; 2) identification and telephone contact with key informants; 3) preparation of an issues paper which summarized the literature reviewed and the comments obtained from the key informants; and 4) preparation of a final report, including recommendations.

Because of the exploratory nature of the study, a key informant design was used. Individuals were identified within various agencies which serve emotionally handicapped Indian children. Based on prior knowledge and referrals, key persons within the Indian Health Service, state mental health, education and children's services agencies, and tribal child welfare, mental health and education programs were identified and contacted by telephone. Those individuals were asked to respond to a series of questions. Anonymity of respondents was assured to allow free expression of concerns. Comments are summarized so that specific agencies or programs cannot be identified.

While the study's primary focus was on the emotionally handicapped population, the study also considered some issues related to Indian children with the dual diagnosis of emotional handicap and developmental disability. This summary mentions service delivery problems of the developmentally disabled when such discussion serves to enhance the understanding of the emotionally handicapped population.

This summary reports the findings in the following manner: first, brief background information regarding the target area and population of the study; second, summary of the issues identified in the literature and by key informants organized by study objective; and third, questions for further study and recommended strategies for improved service delivery.

State/federal program informants (Indian Health Service, state departments of mental health, education and children's services) were asked five general questions:

- Does your agency or department keep statistics on the number of emotionally handicapped Indian children receiving services through your department? If so, how many children receive services per year?
- Does your agency experience any unique difficulties in providing services to emotionally handicapped Indian children?
- How does your agency/department interact with Indian tribes, organizations, or agencies with regard to service for emotionally handicapped Indian children?
- What are the primary problems you or your department have identified in delivering services to Indian children, i.e., lack of resources, jurisdictional issues, community attitudes, parental attitudes, interagency communication, other?
- What seems to be working in this area?

Tribal program informants (Indian child welfare, mental health and education) were asked a series of more specific questions:

- How frequently does your program encounter children who are seriously emotionally handicapped?
- Of your present caseload, about what percentage do you consider to be seriously emotionally handicapped?
- Of those children considered seriously emotionally handicapped:
  - -how many have been evaluated by a mental health professional?
  - -how many do you believe fit into this category, but are not evaluated?
  - -how many are receiving mental health services?
  - -how many are in and out of home care (foster care or institutions)?
- In general, do children receive the services they need?
- Where do these children usually receive mental health services?
- What are the primary barriers to these children obtaining services?
- Do the parents of emotionally handicapped or developmentally disabled children usually know how to get services?
- What is the prevailing community attitude toward emotionally handicapped children?

Background

The scope of this study was limited to the Pacific Northwest. Oregon, Washington, and Idaho contain numerous tribes and urban Indian organizations. The Portland Area Indian Health Service, the Portland Area Office of the Bureau of Indian Affairs, and the Northwest Indian Child Welfare Institute each serve this region as its primary target area.

Currently, there are 37 federally-recognized tribes and several other tribes without federal recognition. They range in size from 61 to 8,500 members.

Coastal tribes have a very different history and culture than do tribes located east of the Cascade Mountains. Historically, a different language base and set of tribal customs separated these tribal groups. Today, several tribes have developed their natural resources and economies. Accordingly, these efforts help support social service programs. Most tribes, however, rely on state or federal programs for service. Some tribes provide their own services through contracts with state or federal agencies. With limited exceptions, Public Law 83-280 (1953) places civil and criminal jurisdiction on reservations within the States of Oregon and Washington. In Idaho, a limited P.L. 83-280 state, the state and tribes have a complex system of civil and criminal jurisdiction on reservations. These jurisdictional issues are mentioned because they play a key role in determining the responsibility for service provision and because the Northwest presents a variety of possibilities for jurisdictional conflicts and service delivery problems.

In the Northwest, the 1980 census reported a total Indian population of 108,533. A total of 41,445 were children under 17 years of age. Approximately 51% (21,092) of these children were on reservations. The remainder were located in urban areas or off-reservation rural areas.

As is indicated by these figures, Indian children may be located in any urban, rural, or reservation locale. They may be served by tribal, state, federal, or private agency programs. A portion of the Indian population, particularly the urban population, is made up of members of tribes from other areas of the country.

Many cultural groups are represented. Tribal beliefs and practices vary from tribe to tribe. Indian people from outside the Northwest add a wide variety of cultural backgrounds to the already diverse population. Today, tribal economies differ greatly as some tribes have abundant land and natural resources while others have little or none. Service delivery issues are strongly influenced by the variety of communities, legal relationships, cultures, and geographic locations.

Findings

Objective I: Estimate the number of Indian children in Oregon, Washington, and Idaho who are seriously emotionally handicapped.

In order to identify the approximate number of Indian children who are emotionally handicapped, we considered several pertinent questions. First, did any current or recent literature, reports or studies address this objective? Second, what agencies or programs, if any, maintain such statistics? Third, if such statistics are kept, what criteria are used to classify a child as emotionally handicapped? Our study intentionally left the definition of emotional handicap to the respondents in order to gain a sense of the operational definitions which exist at the program level.

Unfortunately, our rather exhaustive review of the literature revealed no readily available articles, reports, or studies which address the number of Indian children considered emotionally handicapped. Generally, minority children with mental health problems often are not identified and go without appropriate treatment. Non-white children are less likely to receive all forms of treatment and are particularly likely to be served in correctional facilities (1). Gould, Wunsch-Hitzig, and Dohrenwend estimate that the nationwide incidence of emotional disturbance is 11.8% of the population under 18 (2). Though there seems to be much conjecture about this estimate (3). If applied to the census count of Indian children in the Northwest, we could expect to find approximately 4,900 emotionally handicapped Indian children in the Pacific Northwest. However, cultural, economic, social and historical differences, coupled with the failure to identify minority children in need of services, render such an extrapolation of the national estimates virtually meaningless. For a clearer picture of the numbers we hoped agency statistics would be available.

Unfortunately, we found that none of the states we studied (Oregon, Washington and Idaho) keep statistics on emotionally handicapped Indian children. Two states indicated that producing such statistics might be possible, but would require substantial effort and computer reprogramming.

Indian Health Service representatives report that they have not yet determined whether they could produce such statistics. Further, they would only have information on children served by IHS clinic mental health staff.

The Bureau of Indian Affairs has no such statistics. Tribal programs gave estimates based on the memory of workers and on their varying definitions of emotional handicaps. Of 38 key informants representing 38 tribes, 21 felt they did not have enough information about frequency to respond; 4 had not encountered emotional handicaps; 6 felt they seldom encountered them; and 7 felt they periodically encountered such cases. None felt they occur frequently. Some

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(1) Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund, p. 6.
(2) Gould, M., Wunsch-Hitzig, R., & Dohrenwend, B.P. (1980). Formation of hypotheses about the prevalence, treatment and prognostic significance of psychiatric disorders in children in the United States. In Dohrenwend, B.P., Dohrenwend, B.S., Gould, M.S., Link, B., Neugecauer, R. & Wunsch-Hitzig, R. (Eds.), *Mental Illness in the United States*, New York: Praeger Press, 9-44.
(3) Lourie, I.S. and Katz-Leavy, J. (1985). *Severely emotionally disturbed children and adolescents.* Rockville, MD: NIMH, p. 11-12.

tribes reported no cases, while others reported up to 20% of the youth population as being emotionally handicapped. This diversity seems to suggest very different operational definitions or attitudes about emotional handicaps. It also confirms that no agency has readily available statistics.

Summary of Findings: Objective I

The task of learning the extent of the problem is difficult. However, given the prevalence of school failure, adolescent suicide, alcoholism, involvement in the juvenile justice system, and out-of-home placement rates, one might expect the numbers to be substantial. Based on the range of educated guesses about numbers, 11% to 20% of all Indian children in the Northwest suffer some degree of emotional impairment.

The key informant methodology is clearly not a reliable tool to gather information on frequency, but it did point out major findings: the extent of the problem is unknown, statistics are not available, and operational definitions are lacking at the program level (as indicated by the large number unable to respond). Considering the national estimates for all children, the observations of some of the key informants, and the lack of accurate data, the actual scope of the problem remains unknown.

Objective II: Identify current services for emotionally handicapped Indian children.

Emotionally handicapped Indian children are served by a complex variety of systems with overlapping responsibilities and jurisdictions. What is being done to serve these children varies according to tribe, residence on or off reservation, and severity of the problem. Looking at the differing systems which share responsibility for these children gives the observer an idea of the complexity of the service delivery system.

Federal

Bureau of Indian Affairs - The BIA provides social services to tribes, either directly or via contracts. BIA Social Services are characterized as last resort: that is, they are available only when services cannot be obtained from other sources. No specific services for emotionally handicapped children are provided; however, in the course of their work with families, BIA social workers (or contract workers) may be in contact with such children. Their primary role is referral. Further, many adolescents who might otherwise be considered emotionally handicapped and in need of mental health services, are placed in Chemawa, a BIA-operated boarding school. It remains unclear how many of these placements fit this description, but informants report that it is not uncommon. Some mental health services are available as a part of the boarding school. The school, however, is considered an educational facility and not a treatment facility.

Indian Health Service - The IHS operates health clinics at several reservations and urban settings across the Northwest. These clinics may be directly accessed or contracted by the tribes or urban organizations. Several of these clinics offer mental health services. Though primarily serving adults, some mental health services are available to children. As part of this service IHS has entered into a contract with The American Association of University Affiliated Programs (AAUAP). In the Northwest the AAUAP facility is the Crippled Children's Division of the Oregon Health Sciences University. Under this contract AAUAP provides interdisciplinary evaluations of Native American children and youth. Six evaluations were contracted for in Fiscal Year 1984 (4). Another AAUAP facility, the University of Albuquerque, provides evaluations which are culturally specific. The AAUAP contract covers both the emotionally handicapped and the developmentally disabled.

State

Mental Health Division - Each state mental health division provides some services to Indian children, but none could report how frequently. Services in at least one case were contracted out to a tribal program. State informants reported that Indian children are treated just as any other population. In one state, Indian children were reported to be over-represented in the state mental hospital (10% of the inpatient population versus 1% of the state-wide population).

Children's Services - State children's services agencies provide about two-thirds of the child welfare services provided to Indian children. They have a role in identifying and securing treatment for emotionally handicapped Indian children. Coordination between tribes and state children's services is considered better than with other state agencies.

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(4) Keiter, J.B. and Carlson, L.D. (1985). *Dual diagnosis of Native American children and youth: A case presentation.* Paper presented at the National Native American Conference on Developmental Disabilities, Albuquerque, New Mexico.

Juvenile Justice - While the extent and character of the service remains unclear, informants believed that many Indian youth who might otherwise be viewed as emotionally handicapped are served in the juvenile justice system.

County

County mental health programs provide services to Indian children on the same basis as the rest of the population. No special Indian programs were found and coordination with tribal programs was reported as minimal.

Local Schools

Non-Indian school districts serve emotionally handicapped Indian children under the auspices of P.L. 94-142. Local schools with Indian pupils have Johnson-O'Malley and Indian Education Act Title IV programs which provide a variety of counseling or remedial education services. While they are not equipped to deal with severe emotional handicaps, they assist with referrals.

Private Agencies

Informants reported that private agencies provide at least some mental health services to emotionally handicapped Indian children. These include outpatient counseling, foster care, and residential treatment. The exact role of the providers and frequency of the services provided remain unclear.

Tribal Programs

Several tribes operate mental health, Indian child welfare, Head Start, school and group home and/or alcohol treatment programs which provide information and referral services to emotionally handicapped children. A few programs provide treatment. Tribal programs have developed over the past ten years and are assuming increasing responsibility for providing services to this population. The capacity for evaluation and treatment remains limited.

Urban Indian Programs

Several urban Indian programs provide some mental health services to children. Referral services are provided as well as crisis oriented outpatient services.

Summary of Findings: Objective II

It appears that services for emotionally handicapped Indian children are provided by several different systems. Most Indian programs have only a modest capacity for evaluation and treatment. Few non-Indian programs have strategies for serving Indian children appropriately. This was exemplified by one state respondent who reported being unconcerned with cultural issues, and others who reported that, in a time of scarce resources, agencies cannot afford to give special attention to such a small minority of cases. Most respondents from state agencies felt that, in principle, more attention should be given to cultural issues, but believed this was unlikely under present conditions.

The major finding related to this objective is simply that no single system has assumed primary responsibility for this population. Given that so many systems are involved and that no one has assumed primary responsibility, only those children whose behavior absolutely demands intervention actually receive services. Even then, the service provided is more likely to be what is available, rather than what is needed.

Objective III: Define service delivery barriers to this population.

Most of the findings of the study relate to this objective. A variety of barriers and related issues were identified and will be discussed by topic area. The major topics which follow are: 1) system barriers, 2) community barriers, and 3) practice barriers. Each has sub-topics which are briefly discussed.

SYSTEM BARRIERS

Several barriers were identified which have to do with the nature of the service delivery system. Jurisdiction, funding, interagency communication and tribal status were all topics of concern mentioned by key informants.

Responsibility/Jurisdiction

The issues of jurisdiction, both in a legal and in a programmatic sense, are complicated by the reality of a complex system. They are also complicated by the perceptions of Indian and non-Indian service providers. The reality is that a large number of systems overlap. The perception is that the "other" agency is responsible. Federal, tribal, state and local governments all bear some degree of responsibility for the mental health of children. The boundaries between tribal, state, federal and local responsibility differ from tribe to tribe and from state to state. In most cases the boundaries are so legally complex that they are unclear at the practice level. This complexity leaves the system vulnerable to confusion over differences in interpretation. For example, several tribes reported that state and local agencies are reluctant to provide services because of the perception that such services are or should be federal or tribal responsibility. The responsibility issue is made worse by the fact that mental health resources are scarce for all children.

This area is further complicated for a few tribes in the Northwest that are not federally recognized, either because their tribal status was terminated or because they are not parties to a treaty with the Federal government. Contrary to the belief of many state agency decision makers, such tribes receive no federal assistance.

Public Law 83-280, which allows civil and criminal jurisdiction on Indian reservations to rest with state and local governments, further complicates the responsibility issue. While all states surveyed are P.L. 83-280 states, there are tribes within the three states which are exempt from state jurisdiction. The Confederated Tribes of Warm Springs in Oregon, for example, is exempt, while every other tribe in that state is under state jurisdiction. Idaho is a limited P.L. 83-280 state. Accordingly, Idaho has elected to assume jurisdiction in some matters, but not in others. Briefly stated, the responsibility for services and the relationship between the tribe and state can only be sorted out on a case-by-case basis. Even on those reservations which clearly have jurisdiction, services to emotionally handicapped children are extremely limited.

The Indian Child Welfare Act of 1978 (P.L. 83-280) also influences whether a tribe will have jurisdiction over an emotionally handicapped child. If services involve a change in custody or if the child is already in the child welfare system, the child's tribe may have jurisdiction. Indian children in urban areas are also protected under this Act. When a tribe cannot or does not assume jurisdiction, the child in need of child welfare services comes under the jurisdiction of the state.

While the Indian Child Welfare Act was designed to enable tribes to maintain control over child welfare matters involving tribal members, several tribes reported difficulty in retaining any control when the child is in need of treatment. If the tribe has jurisdiction in a case in which a child needs residential treatment, the tribe is often required to relinquish jurisdiction to the state. This happens

because tribes usually do not have the financial resources to pay the high cost of treatment. The state will not recognize a tribal court order and will pay for the service only if the state has custody. Tribes not only lose custody of the child, but also the ability to monitor and ensure that treatment is appropriate to the cultural needs of that particular child. Most treatment resources are located at a great distance from the tribe as well, making the continued involvement of the family difficult.

Responsibility for service to emotionally handicapped Indian children is undefined at both the program and the practice levels. Children in need of treatment are often caught in a kind of limbo waiting for a responsibility issue to be settled. Or, they are placed in the only available alternative rather than one designed to meet their needs. Key informants reported that funding is at the heart of responsibility issues.

Funding

Lack of adequate funds to develop or deliver services was mentioned by every key informant as a major block to meeting the needs of emotionally handicapped Indian children. From the state perspective it was a matter of allocation of limited resources. Representing only a small minority, Indian children were not seen as a priority. One informant from a state program reported that Indian children are treated no differently than other children and that, considering the resources, there is neither enough time nor enough money to focus on minority issues. Others at the state level agreed that this was the reality, but saw it as unfortunate.

Respondents believed that federal funds are unavailable to tribes on an equitable basis. For example, Title II, Indian Child Welfare Act funds are awarded on a year-to-year basis under a competitive grant-making process. Less than one-half of the tribes in the Northwest receive such funds. The average grant to a tribe, about $50,000, is not large enough to fund special services to emotionally handicapped children.

The Indian Health Service, which provides some mental health services to children, does so either directly or through contracts with the tribe. Levels of services to emotionally handicapped children differ among tribes based on funding and local priorities. Funding priority was reported to be given to physical, rather than mental, health needs. The mental health needs of adults reportedly take priority over those of children.

Tribes usually cannot support services beyond crisis intervention for emotionally handicapped Indian children. The limited funds available are usually allocated primarily for basic services such as child protection and physical health care. Even when tribes contract with the Indian Health Service to provide their own mental health services, the funds for services to children are limited. Resources for specialized treatment, particularly day or residential treatment, do not currently exist. The exceptions are two treatment oriented group homes operated by the Warm Springs and Muckleshoot Tribes. Often, the expertise needed is not available within the Indian community and requests for assistance from state agencies create a dispute over responsibility for the costs incurred. An example was reported in which an Indian adolescent with emotional problems was placed in residential treatment by a state agency in cooperation with the tribe. The youngster needed surgery in order to restore normal vision and appearance as a part of his treatment. A dispute ensued over the reponsibility to pay. The state agreed to pay for the service only after it obtained legal custody of the child.

Key informants felt that funding problems make the responsibility issues more difficult. Conflicts which arise over who pays and perceptions of who should pay create tension between service providers at the program level and thereby function as barriers to service delivery.

Isolation

Some of the informants on reservations felt strongly that services from state agencies are difficult to obtain because of the remoteness of the Indian community. In general, the more geographically isolated the tribe, the less satisfaction informants expressed about cooperative use of services and referrals between Indian and non-Indian agencies. Most agencies will not send staff onto the reservation to work with a child, and transportation of the child to an agency miles away can be nearly impossible. The amount of contact between the client and the service provider was considered by tribal informants to be less frequent than necessary for the improvement of the child's condition. Obviously, the cost of transportation is an issue, but also at issue is the ability to make services available where they are needed.

The BIA provides some services for reservation Indians that are, theoretically, sufficient to replace unavailable state service in those areas. However, the quantity and quality of service provided as compared to that provided off reservation, was often questioned by informants.

As mentioned previously, children whose emotional problems are such that treatment is deemed necessary are frequently removed from their community and family. Often, non-Indian homes or institutions far from the reservation are the only resources which put a child within reach of necessary services. Distance from home and community make family involvement and re-entry into the community difficult. Children are also removed from the support systems of extended families and placed in a culturally unfamiliar environment.

COMMUNITY BARRIERS

A second set of barriers to services was identified which are community based. Community awareness and attitudes about emotional handicaps and mental health services reportedly affect services to emotionally handicapped Indian children.

Awareness

Historically, individuals with emotional problems have been viewed in most Indian communities as being out of harmony: that is, "out of synch" with the natural order of existence. In other instances, behavior which would be seen as "crazy" in Western society was interpreted as "special" in the Indian community. Individuals were accepted and often treated in ceremonies involving the whole community. Problems were viewed as caused by factors outside the person, usually spiritual in nature. Little stigma was attached to such problems. The dominant society has fostered the concept of mental illness and its concomitant stigma.

Key informants were reluctant to speculate on the extent to which the old beliefs still operate. One informant felt that a wider range of behavior is still accepted in the Indian community than would be accepted by non-Indians due to traditional cultural beliefs concerning behavior. Another felt that emotional disturbance was usually not perceived as such unless viewed by a person trained in one of the non-Indian mental health professions. Other informants felt that Indian children do not receive mental health services because there is not enough community awareness about the need for treatment or the resources available. Still others felt that families are reluctant to seek formal services because, historically, they have been either ineffective or unavailable, or have meant the loss of children to the system.

Attitudes about Services

The predominant perceptions about mental health services identified in the Indian community include a historic distrust of the dominant society approach to dealing with mental health (5). This distrust is based not only on different cultural approaches, but also on the belief that formal mental health services are an extension of the dominant society's attempts to assimilate the Indian. Past negative experiences reinforce this lack of trust. A perception exists that non-Indian service providers do not understand Indian culture, retain stereotypic images, and use approaches and techniques designed for the dominant society (6). A belief that formal mental health services tend to be judgmental, demanding and inconsistent (7) also contributes to the lack of service usage. Informal and traditional forms of help, such as use of extended family, are reported to be used much more frequently than formal services.

TRAINING

Key informants felt that a lack of adequately trained Indian service providers contributes to the failure to meet service needs. Most tribes do not have Indian staff who can diagnose emotional handicaps. Tribal programs must rely on outside agencies or non-Indian staff for such judgments. Without more Indian professionals making treatment decisions, Indian people lose self-determination. Further, a body of knowledge about the culturally unique mental health issues of Indian children can be developed best by Indian professionals from local communities.

Informants were also concerned that non-Indian providers, whether they worked for the tribal or state agencies, did not receive adequate cultural awareness training to make them competent within the Indian culture. Without an understanding of cultural differences and the unique needs of Indian children, it was reported that mental health services sometimes make the situation worse instead of better.

PRACTICE BARRIERS

Practice issues constituted an additional set of barriers which were identified in the literature and by informants. Both the diagnosis and the etiology of emotional handicaps in Indian children were considered to be key issues. Treatment was considered to be dependent on the understanding of these issues.

Diagnosis

Proper diagnosis of emotional handicaps in Indian children is complicated by several factors. First, behavior which is considered dysfunctional or "pathologic" in the dominant society may not be viewed as such in Indian communities. For example, in the dominant society, lack of eye contact, a "weak" handshake and soft voice tone may be interpreted as signs of low self-esteem, depression, or passivity. In some Indian groups, such behaviors are merely valued mechanisms which communicate respect and humility. When the normal behaviors, symbols or values of one culture are different from the evaluator's concept of "normal," assessments are not only inadequate and incomplete, they are clearly inaccurate.

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(5) Lockhart, B. (1981). Historic distrust and counseling of American Indians and Alaska Natives. *White Cloud Journal of American Indian Mental Health, 2*(3), 31-34.
(6) Lewis, R. and Man, H. (1975, September). Social work with Native Americans. *Social Work, 20*(5), 379-386.
(7) Dana, R.H. (1984). Intelligence testing of American Indian children. *White Cloud Journal of American Indian Mental Health, 3*(3), 35-41.

When the child's primary language is other than English, the influence of language is especially challenging in diagnosis, both because of the barrier this may present to the evaluator and because native languages often have words for concepts which do not exist in English and vice versa.

The interpretation of symbols in projective testing likewise can become a point of error because symbols may have culturally specific meaning. For example, one informant spoke of a girl who placed an owl in a family drawing. Unless the evaluator knew that this was a symbol of death in her tribe, interpretation of the drawing would have been inaccurate.

The degree of assimilation into the dominant society influences behaviors, values, and communication styles and, thus, a culturally relevant assessment must consider how traditional or how assimilated the child is. Each family environment will exhibit a variety of culturally determined values and behaviors relative to its degree of assimilation. A child who has experienced bonding in an extended family system with multiple-care givers will develop differently from a child reared in a nuclear family environment.

Indian child rearing practices and values may influence how the child appears to be developing. For example, traditional culture tends to value child autonomy, but also encourages interdependence. Separation and individuation may not occur in the same way under differing cultural circumstances. Similarly, the cultural emphasis placed on spatial skills and non-verbal communication versus verbal expression, as well as the emphasis on cooperation rather than competition, cause Indian children to be viewed as passive or as having low self-esteem when judged by dominant society standards. Current child development theory provides an inadequate knowledge base regarding the influence of cultural differences on development so that the nature of "normal" development in many minority communities remains undefined. Clearly, it is extremely important that the evaluator be aware of the cultural issues and that a knowledge base reflecting cultural distinctions be developed.

The influence of organic factors, such as fetal alcohol syndrome, otitis media (middle ear disease) and nutrition must also be considered since these may greatly influence mental functioning and are very prevalent in Indian communities.

Although some attempts have been made to compensate for cultural bias in intelligence testing, the literature reflects a deficit in the area of personality testing. All forms of testing are plagued with a lack of norms for Indian children. SOMPA (8) has been used to provide corrections for culture that may be applied to WISC-R scores, but this approach has been criticized (9). Little work has been done to date in the area of personality testing, which is strongly affected by the factors listed above. At present only cultural awareness on the part of the evaluator can compensate for culturally biased instruments.

Etiology

Appropriate services to emotionally handicapped Indian children are also complicated by several factors concerning the etiology of emotional handicaps. While these factors are not direct barriers to service, we consider them here because not enough is understood about their impact. Lack of knowledge about etiology is the barrier.

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(8) Mercer & Lewis, 1978, as cited in Dana, 1984.
(9) Oakland, 1979, as cited in Dana, 1984.

What kinds of stress do Indian children and youth face which may negatively affect their mental health? One must consider a history of pervasive out-of-home placements in non-Indian settings and in federally operated boarding schools. Many current parents and grandparents were reared in institutions without the benefit of parental role models. Children today are often reared by parents who were deprived of nurturing, rites of passage and cultural identity. Mixed race or mixed tribal status children face the additional challenge to their mental health of not knowing where they belong. Further, the economically depressed nature of Indian communities, the high rate of alcoholism and suicide, and the isolation factor create a unique environment in which to view child mental health. As mental health professionals begin to examine the cultural variables in bonding, development, and family functioning, a clearer picture of the etiology of Indian child mental health will emerge.

It is apparent that a variety of unique factors impact the mental health of Indian children. Further knowledge about these factors is needed to develop a culturally relevant theory base from which appropriate services can be derived.

Summary of Findings: Objective III

In response to Objective III, system, community, and practice barriers to service delivery were identified. Diffuse responsibility, lack of funding, and isolation were seen as the primary system barriers. Needs for increased awareness, improved attitudes, and training were identified as community barriers. The need for culturally biased diagnosis and lack of knowledge of etiology were seen as the primary practice barriers. Jurisdiction and responsibility are complex, undefined and vulnerable to interpretation. Overlapping state and federal laws confuse the issue of who is responsible. Funding levels are perceived as inadequate to meet the need and monies are inequitably distributed when available. Geographic isolation, lack of understanding of the problem, and negative community perceptions about mental health services inhibit service development and delivery. Service providers were viewed as undertrained in both the unique mental health needs of Indian children and in cross cultural practice. Finally, accurate diagnosis and appropriate treatment were viewed as limited due to biased assessment tools and the lack of a theory base which reflects cultural beliefs and practices. Each of these barriers seem to be interrelated with each of the others. As a whole, the informants felt that the problems of emotionally handicapped Indian children and the barriers to services were not well understood.

Objective IV: Identify exemplary programs and innovations for successfully addressing with the problems of emotionally handicapped Indian children.

In an effort to determine what was working well, several approaches and programs stood out in conversations with key informants. Two tribes in the Northwest operate group homes. One has a strong treatment orientation and has made substantial progress in linking natural helping systems with formal ones. A third tribe has taken a strong stance on prevention while a fourth emphasizes parental and community involvement. One urban program has taken an innovative approach in the treatment of alcoholism and the children of alcoholic families.

Both the Confederated Tribes of Warm Springs (Oregon) and the Muckleshoot Tribe (Washington) have developed group homes. Operated and staffed by the tribes, these group homes offer an alternative to off-reservation treatment. The group home at Warm Springs serves adolescents with a treatment philosophy which is culturally based. As a modernization of an ancient tradition in which designated members of the tribe serve as teachers and disciplinarians, the group home has become an important part of the community (10). Cultural teachings are incorporated as a part of the treatment process.

Also at Warm Springs, the community counseling program employs a para-professional who acts as a link between the natural helpers in the community and the formal services. By giving and receiving referrals from traditional healers, clergy, and other natural helpers, this person is able to assure that a holistic approach to mental health is accomplished.

In Washington State, the Skokomish Tribe has taken a strong proactive stance on prevention. Realizing that sexual abuse is a major source of emotional problems, the tribe has developed a sexual abuse prevention program with the support and encouragement of its elders. This effort, a part of their child welfare program, is closely linked with mental health services.

Development of parent and community involvement is an approach being tried by the Quinault Indian Nation in Washington. This new program is bringing traditional elders, tribal government, service providers, and parents together to find solutions to child welfare and mental health problems unique to that community.

In Portland, Oregon, the Native American Rehabilitation Association (NARA) is using innovative approaches in the treatment of alcoholism and related mental health issues. Using an approach known as Indian self-actualization, NARA helps clients examine their own identities, clarify values, and develop skills to cope with cultural differences. This helps clients develop a sense of who they are and how they can maintain personal and cultural strengths. NARA is also unique in that it treats both adults and children. In the women's center, a residential facility, women can enter treatment and bring their children with them. Mothers receive alcoholism treatment and help with parenting while children receive help with socialization and cultural identity formation. Child care workers act as role models and reinforce positive gains of parents.

In a more general sense, tribes and urban Indian programs across the Northwest are operating Head Start and other pre-school programs, which encourage positive

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(10) Shore, J. and Nicholls, W. (1975). Indian children and tribal group homes: New interpretations of the whipper man. *American Journal of Psychiatry, 132*(4), 454-456.

self-image and cultural identity in Indian children. Health programs for women, infants and children are encouraging positive parenting relationships. Several tribes are conducting parent education programs and new culturally specific parent curricula are in production.

While these are only a few of the positive approaches being taken, the experience of informants suggests that most advances in helping this population are resulting from a growing body of knowledge and expertise in Indian communities.

General Comments

Increased national attention has recently been given to the needs of severely emotionally handicapped children. Jane Knitzer has brought many of the issues into focus through her book Unclaimed Children. While minority issues are discussed briefly by Knitzer, relatively little is known about how emotionally handicapped Indian children fare in the system. With increasing legal responsibility and expertise concerning their children, Indian tribes have identified many of the same issues mentioned by Knitzer as affecting their own children. But there is more. There is, in fact, an entire set of issues and dilemmas which arise out of the unique governmental and bureaucratic structures which affect Indian people. In addition, there are unique cultural and cross-cultural factors to consider. Services for all children in general are complicated by overlapping bureaucratic structures, e.g., education, mental health, child welfare. For Indian children, the complications are doubled or tripled as federal, state, and tribal services also overlap. To sort out this maze of interrelating entities is a monumental task. This report is a beginning. It is an attempt to sort out some of the issues in order to call attention to them and suggest possible approaches for improvement and further study.

Questions and Recommendations

Many questions were left unanswered. New questions were generated as we gathered information. Following are several questions and recommendations which have arisen from the study:

Question: What is the extent of the problem?

While our initial intention was to make an educated guess about the extent, we were unable to do so due to the pervasive lack of numerical data as well as the lack of operational definitions of emotional disturbance.

Recommendation: It is recommended: 1) that efforts be made to encourage service providers at the state, federal, and tribal level to reorganize data collection to reflect the number of emotionally handicapped Indian children served; 2) that operational definitions of emotional handicaps be developed for this purpose; and 3) that a quantitative investigation be undertaken to examine the extent of the problem.

Question: Some key informants reported little or no incidence of emotional handicaps in their communities. Was this because the communities were small and there were none, or because they were not identified as such?

Recommendation: It is recommended that a quantitative study be designed to find those cases which might not be labeled in the community as "emotionally handicapped," but which would be if there was more awareness of the problem. Such a design might look for certain behaviors indicative of emotional handicap and seek information from several sources, i.e., schools, parents, mental health clinics, etc.

Question: Various factors regarding the etiology of emotional handicaps were suggested. What is the impact of these socio-cultural factors and what weight do they have in the psychic/environmental balance of mental health for Indian children?

Recommendation: Further investigation is recommended into the nature of the socio-cultural factors (e.g., cultural identity and stress of assimilation) which impact Indian mental health.

Question: Given the complex nature of the governmental and bureaucratic relationships involved, how can the responsiblity issues be solved?

Recommendation: Further clarification is necessary and open dialogue between the entities involved is essential. It is recommended: 1) that a means be created to encourage this dialogue; 2) that a mechanism be created by which responsibility issues can be arbitrated without the loss of tribal sovereignty or self-determination; and 3) that tribes be empowered to provide necessary services to their own children.

Question: Given limited funds and resources, how can the needs of emotionally handicapped Indian children receive the attention they deserve?

Recommendation: It is our assertion that funds devoted to the needs of emotionally handicapped children in general are both inadequate and inequitably distributed. Indian Child Welfare Act funds are an example. A more equitable distribution and a revision of the current funding mechanism are recommended.

Other Recommendations

It is also recommended that:

1. Services be made more accessible to Indian families and that placement away from families and other support systems be avoided.

2. Efforts be made to inform and educate local Indian and non-Indian professionals, para-professionals, school personnel, etc., as to the indicators of emotional handicaps.

3. Efforts be made to meld traditional knowledge of balance and harmony with modern concepts of mental health into training curricula which encourage culturally appropriate practice.

4. Core curricula in mental health training institutions include materials designed to make all mental health professionals aware of the importance of cultural differences.

5. Research into the design and use of diagnostic tools, such as projective testing, be conducted to examine the cultural bias of such tests.

6. Publication and dissemination of the existing and potential knowledge base in this area be encouraged and supported on an ongoing basis.

Conclusion

An investigation of this type is not designed to be scientific, but rather to draw together experiences in order to present a picture of the current state of affairs. In this case, it is a complex one. Each new perspective offered by informants gave indication that the dimensions of the problem are far beyond the scope of a single exploratory study. To conclude that the number of emotionally handicapped Indian children can only be a guess and to determine that no one seems to have clear responsibility or enough funds to serve these children may surprise no one. However, we are left with the fact that an Indian child in need of mental health services may not have that problem recognized, and even if recognized, appropriate diagnosis and treatment of the problem is likely to be unavailable. Unrecognized and untreated mental health problems of Indian children develop into repeating cycles which rob Indian families and communities of needed energy and human resources. For the Indian child who cannot cope, the system, community and practice barriers have little personal meaning, and yet they may mean the difference between no hope and a chance for a healthy, productive life. Further clarification of these barriers and creative solutions are imperative if emotionally handicapped Indian children are to have hope for the future.

Identification of the responsibility and jurisdiction issues as barriers implies that such problems can be overcome through changes in legislation, regulation, and policy. So, too, can practice barriers be overcome by the further development of the knowledge base and culturally specific curricula in schools of social work, psychology, and medicine. Significant progress is already being made in this area as evidenced by program successes cited in this study. As the exact nature of community barriers become better defined, community solutions can be developed and implemented.

A necessary element in the process of change will be a voice for this minority within a minority. Further study and dissemination of the results regarding these issues will greatly enhance the prospects for improvement and give advocates information needed to promote improved services. Our hope is that this exploration will be followed by others armed with better questions and more precise tools. Bleak though the current picture may be, it is clear that the needs of the emotionally handicapped Indian child are beginning to receive attention. The discussion of the informants' impressions of barriers and successes presented here evidence the strong concern developing in Indian communities for these children.

SELECTED BIBLIOGRAPHY

Berlin, I.N. (1982). Prevention of emotional problems among Native American children: Overview of developmental issues. *Journal of Preventive Psychiatry, 1*(3), 330.

Commission on Indian Services. (1984). *Report on the assessment of human resource services to American Indians in the state of Oregon.* Report presented to Oregon Commission on Indian Services, Salem, OR.

Dana, R.H. (1984). Intelligence testing of American Indian children: Sidesteps in quest of ethical practice. *White Cloud Journal of American Indian Mental Health, 3*(3), 35-41.

Fields, S. (1979). A life in the crowd: A trail of concrete. *Innovations*, Summer.

Fields, S. (1976). Folk healing for the wounded spirit: Medicine men, purveyor of an ancient art. *Innovations, 3*(3), 12-18.

Fields, S. (1979). When MIN means more. *Innovations*, Spring, 19-20.

Fleshanun, C. (1985). Comprehensive health services for developmentally disabled Navajo children. *Developmental and Behavioral Pediatrics, 6*(1).

Keiter, J.B. and Carlson, L. (1985). *Dual diagnosis of Native American children and youth: A case presentation.* Paper presented at National Native American Conference on Developmental Disabilities, Albuquerque, New Mexico.

Kessel, J.A. and Robbins, S.P. (1984). The Indian child welfare act: Dilemmas and needs. *Child Welfare, 63*(3), 225-233.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: Children's Defense Fund, p. 6.

Lewis, R. and Man, H. (1975, September). Social work with Native Americans. *Social Work, 20*(5), 379-386.

Lockart, B. (1981). Historic distrust and the counseling of American Indians and Alaska Natives. *White Cloud Journal of American Indian Mental Health, 2*(3), 31-34.

Long, K.A. (1983, January). The experience of repeated and traumatic loss among Crow Indian children. *Journal of American Orthopsychiatry Association, 53*(1), 116-126.

Lourie, I.S. and Katz-Leavy, J. (1984). *Severely emotionally disturbed children and adolescents.* Rockville, MD: Under-Served Populations Branch, NIMH, p. 11-12.

Marion, R.L. (1980). Communicating with parents of culturally diverse exceptional children. *Exceptional Children, 46*(8), 616-623.

Meketon, M.J. (1983, January). Indian mental health: An orientation. *Journal of American Orthopsychiatric Association, 53*(1), 110-115.

Sack, W.H. et al. (1985, October). *The high achieving Sioux Indian child: Some preliminary findings from the Flower of Two Soils project.* Paper presented at annual meeting of American Academy of Child Psychiatry.